Mecasermin (Increlex) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP) *OR* the TRICARE Retail Pharmacy Program (TRRx). Express Scripts is the TMOP and TRRx contractor for DoD.

MAIL ORDER	RETAIL
IF the prescription is to be filled through the TRICARE Mail Order Pharmacy, check here ☐	**IF the prescription is to be filled at a retail pharmacy under the TRICARE Retail Pharmacy Program, check here** ☐
• The provider should complete the form, sign, and date • The provider may **fax** the completed form and the prescription to **1-877-895-1900** or 1-602-586-3911 (commercial) **OR** • The patient may attach the completed request form to the prescription and **mail** it to the TMOP at: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**	To request prior authorization, the provider may **call** this number: • **1-866-684-4488** OR • The provider may complete the form, sign, date, and **fax** to **1-866-684-4477**

Prior authorization criteria and a copy of this form are available at: http://www.tricare.osd.mil/pharmacy/prior_auth.cfm

Drug for which Prior Authorization is requested: Mecasermin (Increlex)

Step 1 **Please complete patient and physician information (Please Print)**

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID #: _____ Phone #: _____

Secure Fax #:

Step 2 **Please complete the clinical assessment**

1. Is the patient a child older than two years of age with open epiphyses?	☐ Yes Please proceed to question 2	☐ No Coverage not approved
2. Is the patient receiving ongoing care under the guidance of a health care provider skilled in diagnosis and management of growth disorders (e.g., pediatric endocrinologist)?	☐ Yes Please proceed to question 3	☐ No Coverage not approved
3. Does the patient have severe primary insulin-like growth factor (IGF)-1 deficiency (IGFD), defined by the following: ▪ **Height standard deviation score ≤ -3 AND** ▪ **Basal IGF-1 standard deviation score ≤ -3 AND** ▪ **Normal or elevated growth hormone levels**	☐ Yes Please proceed to question 5	☐ No Please proceed to question 4
4. Does the patient have growth hormone gene deletion AND neutralizing antibodies to growth hormone?	☐ Yes Please proceed to question 5	☐ No Coverage not approved
5. Does the patient have any of the following: ▪ **Other causes of growth failure (e.g., growth hormone deficiency, malnutrition, hypothyroidism, chronic anti-inflammatory steroid use)** ▪ **Active or suspected neoplasia**	☐ Yes Coverage not approved	☐ No Please proceed to question 6
6. Has the patient and/or caregiver been educated on how to monitor blood glucose levels, received a glucometer and necessary testing supplies, and demonstrated knowledge of blood glucose monitoring and hypoglycemia management?	☐ Yes Coverage approved for 1 year	☐ No Coverage not approved

Step 3 **I certify the above is correct and accurate to the best of my knowledge** (Please sign and date)

_____ _____

Prescriber Signature Date

Latest revision: January 2006